SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports Screening & Referral Form

Instructions: Complete all sections below. A referral to the Lead Clinical Staff (or Life Skills Specialist) should only be made if a "yes" response is made for all items under 3, 4 & 5 below.

	Person's Name:	DOB:	Medicaid #

Mark all applicable items:

1)	The person receives services through SCDDSN:	☐ Mental Retardation Division	☐ Autism Division	☐ Head and Spinal Cord Injury Division	☐ Other Specify) ex. High Risk Infant)
2)	The person is:	☐ Currently in school	☐ Receiving Community Long Term Care (CLTC) Elderly and Disabled Waiver Services *		☐ Receiving HASCI Waiver Services **

3)	The person has expressed a need to develop, retain, or restore an optimal level of functioning in one or more of the following skills: Self-Care, Community Living Skills, Psycho-Social and/or Medication Management/Symptom Reduction	☐ Yes ☐ No
4)	The person would like to develop an enhanced capacity for personal independence essential for successful community living	☐ Yes ☐ No
5)	The person meets the following Individual Rehabilitation Support eligibility requirements:	
	Meets DDSN eligibility requirements	☐ Yes ☐ No
	Is not enrolled in the MR/RD Waiver	☐ Yes ☐ No
	Is a Medicaid recipient	☐ Yes ☐ No
	Does not reside in an Intermediate Care Facility for the Mentally Retarded or Nursing Home	☐ Yes ☐ No
	Is approved to receive Rehabilitation Support Services by their Service Coordinator or Early Interventionist with authorization from the home board provider	☐ Yes ☐ No

_____ _____

Signature of Service Coordinator/Early Interventionist **Date**

_____ (_____) _____

Provider of Service **Phone**

LCS USE ONLY

SERVICE AWARDED: ☐ **Yes** ☐ **No (explain: _____)** ☐ **Added to Waiting List**

LCS Signature: _____ Date: _____

IRS FORM 1